# Individual Personal-Care Plan for Infants and Toddlers

**Child's Name** _____

**Date of Birth** _____

*What would you like us to call your child?* _____

## Developmental History

Type of birth: _____ Complications: _____

Age child began: sitting _____ crawling _____ walking _____ talking _____

Does child: sit up ☐ pull up ☐ crawl ☐ walk with support ☐

Times child may be fussy: _____

How do you handle these fussy times? _____

_____

## Family Information

With whom does child reside? _____

Who else lives in the home (siblings, extended family, pets)? _____

_____

What does the child call family members? _____

_____

Language(s) spoken at home: _____

Are books read in languages other than English? _____

Are there words/phrases in home language that we should know? _____

_____

Are there cultural or family customs, rituals, or traditions that will help us make your child's experience more meaningful? _____

_____

Are there other matters or concerns you feel are important? _____

_____

## Health / Development

Describe any serious illnesses or hospitalizations: _____

_____

_____

Any history of colic? _____

_____

Describe any special physical conditions, disabilities, or allergies: _____

_____

_____

Has your child been diagnosed with a special need? _____

If so, is your child receiving any special services? _____

_____

Regular medications? _____

_____

## Bottle / Cup Routine

Circle: Bottle Cup

Breast Milk: _____ Amount _____ Time of day you want given _____

Formula: _____ Brand _____ Amount _____
Time of day you want given _____

Milk: _____ Type _____ Amount _____
Time of day you want given _____

Juice: _____ Type _____ Amount _____
Time of day you want given _____

## Introducing Solid Foods

We recommend introducing infant cereal at 4–6 months; vegetables, fruits, and juices at 5–7 months; protein such as cheese, yogurt, cooked beans, meat, fish, chicken, and egg yolks at 6–8 months; whole eggs at 10–12 months; and milk at 12 months. We can introduce the use of a cup and spoon at 8–10 months.

If you do not wish to follow our recommendations, please sign and comment on your preferences: _____

_____

## Eating Routine

Any food allergies? _____

Solid Food: _____ Time of day you want given: _____

Food likes and eating preferences: _____

_____

Food dislikes or eating problems: _____

_____

Special diet/requests: _____

_____

Special characteristics or difficulties? _____

_____

Child eats: ☐ on lap ☐ in high chair ☐ other _____

Child eats with: ☐ spoon ☐ fork ☐ hands ☐ other _____

## Toilet/Diapering Habits

Does your child have frequent diaper rash? _____

Do you use: ☐ oil ☐ powder ☐ lotion _____ ☐ other _____

Does child wear: ☐ disposable diapers ☐ cloth diapers

Are bowel movements: ☐ regular How often: _____

Is there a problem with: ☐ diarrhea ☐ constipation

Is your child toilet trained: ☐ urination ☐ bowels

What is used at home: ☐ potty chair ☐ special seat ☐ regular seat

Word used for urination: _____ bowel movement: _____

Does the child have accidents? _____

_____

## Comforting/Distress

Does your child have a security object? _____ Name? _____

Does your child use a pacifier? _____ When? _____

Other information? _____

What comforting objects would you like your child to have at the program?

_____

## Sleeping Routine

Does child sleep in: ☐ crib ☐ bed ☐ family bed

Pre-nap routines/rituals: _____

_____

How many naps per day (typical): AM _____ to _____ PM _____ to _____

Length of nap: _____

In what position does your child prefer to nap: _____

_____

Waking behavior/routine: _____

Special concerns: _____

What time does child go to bed at night:_____ awake in morning: _____

Are there any sleeptime rituals? _____

## Separation

Has your child been left in the care of someone other than yourself? ☐ yes ☐ no

If so, with whom? _____

What difficulty does your child experience separating from you? _____

_____

What are some ways to calm your child? _____

What are your feelings about leaving your child in our care? _____

_____

How can we help you feel more comfortable and involved in the care of your child? __

_____

_____

## Social Relationships

Has your child had any experience playing with other children? _____

_____

Would you characterize your child as often:
☐ friendly ☐ aggressive ☐ shy ☐ withdrawn

Reaction to strangers? _____

Have you had any previous child care experience? _____

If so, did it meet your needs and expectations? _____

Explain: _____

_____

Does your child prefer to play: ☐ alone ☐ in small groups

Favorite toys and activities? _____

Is your child frightened by:
☐ animals ☐ rough children ☐ loud noises ☐ darkened rooms

Explain: _____

What is your style of guidance and discipline? _____

_____

_____

## Daily Schedule

Please describe by approximate time your child's current daily activities (that is, awakening, eating, time out of crib, napping, toilet habits, fussy time, evening bedtime):

### Morning

_____

_____

_____

### Afternoon

_____

_____

_____

### Evening

_____

_____

_____

## Parenting Philosophy

Do you have ideas about parenting that would help us to better care for your child?

_____

_____

_____

_____

_____

What do you as a family hope to get out of this child care experience?

_____

_____

_____

_____

_____

We will update the personal care plan every 3 months, or sooner if requested by a parent/guardian or as needed by the staff.

Parent Signature _____ Date _____

Staff Signature _____ Date _____

Date of change _____ Parent Initials _____ Staff Initials _____

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